| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 155616 | A. BUILDING _____ B. WING _____ | 03/23/2011 |

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| F0000 | This visit was for the Investigation of Complaint IN00087744.<br><br>Complaint IN00087744: Substantiated - Federal/State deficiencies related to the allegations are cited at F157, F272, and F282.<br><br>Unrelated deficiencies are cited.<br><br>Survey dates: March 21, 22, and 23, 2011<br><br>Facility number: 001145<br>Provider number: 155616<br>AIM number: 200120200<br><br>Survey team: Jennie Bartelt, RN<br><br>Census bed type:<br>SNF/NF: 69<br>Residential: 17<br>Total: 86<br><br>Census payor type:<br>Medicare: 8<br>Medicaid: 53 | F0000 | **This plan of correction is to serve as Landmark Nursing & Rehabilitation Center's credible allegation of compliance.**<br><br>**Submission of this plan of correction does not constitute an admission by Landmark Nursing & Rehabilitation Center or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.** | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| | Other: 25<br>Total: 86<br><br>Sample: 25<br><br>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.<br><br>Quality review completed 3-28-11<br>Cathy Emswiller RN | | | |

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| F0157 SS=D | Based on observation, interview, and record review, the facility failed to ensure the physician was consulted related to a change in treatment orders for 2 of 6 residents whose physician orders were reviewed related to change in treatment in a sample of 25. (Residents T and U)<br><br>Findings include:<br><br>1. During medication pass on 3/21/11 between 10:55 p.m. and 11:25 p.m., LPN #3 was observed pouring a liquid medication from a bottle of Haldol [restlessness] liquid with a label indicating, "Take 0.5 ml (1 mg) subling [sublingual - under the tongue] every 4 hours routinely. May increase to 2 mg [1 ml] if 1 mg ineffective." The medication bottle did not indicate a label noting a change in physician's order. LPN #3 administered 0.5 ml (1 mg) of the liquid medication to Resident T. | F0157 | **F157 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)**<br>I. Resident T's Haldol order was clarified. The medication was labeled with a change in order sticker. Resident T's MAR (Medication Administration Record) was updated. Resident U's medication administration orders were clarified and MAR was updated.II. All residents medication orders were reviewed by RN to assure no other unclear or improper orders were present.III. The policy for medication labeling and administration were reviewed and found to be appropriate by QA. Licensed nurses will be educated on medication administration and lab The DON or designee will review physician's medication orders monthly through the recapping process to assure all medication orders are clear and appropriate routes are indicated. Any discrepancies will be corrected upon identification. The DON or designee will report to QA monthly.V. Compliance Date: April 22, 2011 | 04/22/2011 |

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| | The clinical record for Resident T was reviewed on 3/21/11 at 11:25 p.m. after the medication pass.<br><br>The record indicated a physician's telephone order dated 3/21/11 at 4:15 p.m., for "Give Haldol 1 mg now then start Haldol 2 mg per previous order." The previous order, dated 3/20/11, indicated, "[Arrow pointing up] Haldol to 1 mg p.o. [by mouth] q [every] 4 [symbol for hours] routine. May [arrow pointing up] to 2 mg if 1 mg ineffective."<br><br>The Interdisciplinary Hospice Communication, dated 3/21/11 from 3:15 p.m. to 5:30 p.m. indicated, "...Reviewed meds [medications] & discussed with SNF [skilled nursing facility] - [arrow pointing up] Haldol to 2 mg every 2 [sic] hrs [hours] per order...."<br><br>During interview about the order for the liquid Haldol on 3/23/11 at | | | |

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| | 11:00 a.m., the facility's Nurse Consultant indicated she understood the order on 3/21/11 at 4:15 p.m. to mean that the previous order for 1 to 2 mg of liquid Haldol every four hours should be followed, instead of administering 2 mg with each dose. The Consultant indicated the physician should have been contacted to clarify the medication order and that the order had now been clarified. She provided copy of a physician's order dated 3/22/11 that included, but was not limited to, "Increase Haldol to 2 mg po/sl [by mouth/sublingual]." The time frame for the administration was not indicated on the order.<br><br>2. During medication pass on 3/21/11 between 10:55 p.m. and 11:25 p.m., LPN #3 was observed preparing a medication labeled as follows for Resident U: "Apresoline [blood pressure] 25 mg tab, take 2 tabs per G (gastrostomy) -tube every 6 hours." This order | | | |

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| | was also indicated on the resident's Medication Administration Record in the binder on top of the medication cart. During interview at this time, the LPN #3 indicated the resident no longer received medications by G-tube, since the resident no longer had the G-tube, as the family had requested its removal. LPN #3 administered the medication by mouth.<br><br>The clinical record for Resident U was reviewed on 3/21/11 at 11:25 p.m. after the medication pass. The record indicated physician's orders for March 2011 including, but not limited to, "Apresoline 25 mg tab, take 2 tablets per G-tube every 6 hours." Other medications ordered by gastrostomy tube included Lanoxin [heart], metoprolol [blood pressure], isosorbide [heart], and Cardizem [blood pressure].<br><br>A Nurse's Note for 12/7/10 at 9:00 a.m. indicated, "Res [resident] LOA [leave of absence] to have g-tube | | | |

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| | removed...." A Note for 12/7/10 at 1:00 p.m. indicated the resident returned from the hospital and the gastrostomy tube had been removed.<br><br>During interview on 3/23/11 at 9:45 a.m. related to the physician's order and the route of medication administration, the Administrator indicated, "If the rewrites [of physicians' orders on the monthly plan of treatment] were being checked, you'd [the nurse would] find this" to get the order changed.<br><br>On 3/23/11 at 12:20 p.m., the Nurse Consultant provided copy of a physician's order, dated 3/23/11, indicating, "Clarification - G-tube dc'd [discontinued], give meds [medications] po [by mouth]."<br><br>This federal tag relates to Complaint IN00087744.<br><br>3.1-5(a)(3) | | | |

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| F0272 SS=E | Based on observation, interview, and record review, the facility failed to ensure a resident was assessed for follow-up after the resident reported decreased urinary output. The deficient practice affected 1 of 2 residents reviewed related to decreased urinary output in a sample of 25. (Resident J) The facility also failed to assess the intravenous insertion site of 2 of 2 residents reviewed related to PICC (peripherally inserted central catheters) lines in a sample of 25. (Residents I and M) The facility also failed to assess the need for pain medication before administration for 1 of 6 residents observed receiving pain medication in a sample of 25. (Resident P)<br><br>Findings include:<br><br>1. On 3/22/11 at 12:20 a.m., Resident J was observed seated in his wheelchair at the medication cart talking with the Assistant Director of Nursing (ADON). The | F0272 | **F272 483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS** I. Resident J was reassessed by RN and has had no further issues with voiding. His physician was notified and a urinalysis was completed with no abnormal findings. Orders for dressing changes and daily assessment of PICC site were obtained for Resident I. These dressings are being completed as ordered. Resident I's PICC site is intact with no signs of infection or compromise. Orders for dressing changes and daily assessment of PICC site were obtained for Resident M. These dressings are being completed as ordered. Resident M's PICC site is intact with no signs of infection or compromise. Resident P has been reassessed for pain management and orders have been received. Resident P's pain is currently managed.II. All residents were reviewed for difficulties in voiding, PICC lines and use of PRN pain medications. No other residents were identified with voiding issues or PICC lines. Those residents who routinely require PRN pain medications were reassessed and their physician's were contacted with a request to administer the medications routinely to better manage their pain.III. The facility's policies for PICC line care and PRN | 04/22/2011 |

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| | resident reported he had no urinary output since 2:00 p.m. but had had several drinks of water and juice during the day. The resident indicated he had checked his ankles to be sure they weren't swollen like the other time. The ADON asked the resident if he wanted her to call the doctor for orders to use a catheter to check for urinary retention.<br><br>The clinical record for Resident J was reviewed on 3/22/11 at 11:30 a.m.<br><br>Nurse's Notes for 3/22/11 at 12:30 a.m. indicated, "Res [resident] c/o [complained of] not being able to urinate. States 'I haven't peed since 2 p.m.' Res abd [abdomen] non-distended. Active bowel sounds X [times] 4 quads. States he has been drinking fluids throughout day. States he does dribble urine at times. States he has been doing this for the past couple days but has not told anyone. Dx [diagnoses] of | | medication administration were reviewed and found appropriate by QA. An acute care planning policy was drafted and approved by QA. A new Change in Condition-24 hr report sheet was presented and approved by QA. Licensed nurses will be educated on PICC line care, administration of PRN medications – including but not limited to assessment requirements, assessment of residents with a change in condition, and communication via Change in Condition 24-Hr report sheet and acute care planning.IV. The Interdepartmental Team will review new admissions, readmissions and all new orders daily to assure proper dressing and assessment orders are present for PICC lines. The Interdepartmental Team will review the Change in Condition – 24 Hr report sheet daily to identify any resident with a change in condition and to assure proper assessment, physician notification and plan of care is in place. The DON or designee will review PRN medication administration records monthly to identify the proper assessment of need and to identify any resident who may require the routine administration of a medication versus “as needed”. The DON or designee will report to QA monthly.V. Compliance Date: April 22, 2011 | |

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| | diabetes and chronic renal insufficiency. Res. refuses the idea of being cathed [catheterized] to check urine for possible retention. Explained to Res the MD would be notified of Res. concerns. Res stated he would think about the idea of being cathed, but he does not want to do that at this time. Risk of possible urinary retention explain [sic] and Res verbalized understanding. MD notified."<br><br>Documentation in Nurse's Notes after the 3/22/11 12:30 a.m. note through 3/23/11 at 12:00 a.m. failed to indicate the resident was reassessed related to urinary voiding.<br><br>During interview on 3/23/11 at 12:30 p.m. with the facility's Nurse Consultant in regard to on-going monitoring of the resident's urinary status, the Consultant indicated the resident sometimes had attention-seeking behaviors. She indicated she would check with the | | | |

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| | social worker to see if this was a behavior. She also indicated she would expect a nurse to have assessed the resident related to urinary voiding since the time of the report to the ADON.<br><br>During interview on 3/23/11 at 1:15 p.m., the social worker indicated Resident J sometimes does things to get attention, but she had never known him to complain of "not being able to pee" as a behavior to get attention.<br><br>During interview on 3/23/11 at 1:35 p.m., the Nurse Consultant indicated she had talked to Resident J, and he had reported he was "peeing just fine." She also indicated she had faxed the physician about the resident's complaint. She indicated the resident was on the medication Flomax (for enlarged prostate), and she wondered if that might be a problem for the resident. | | | |

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| | 2. During observation and interview on 3/21/11 at 9:45 p.m., Resident I indicated she had been in the hospital recently and pointed to an intravenous tubing observed in her upper left arm.<br><br>During interview on 3/21/11 at 10:05 p.m., LPN #8, who indicated she was providing care on Resident I's hall this evening, indicated none of the residents on her hall had a PICC line.<br><br>The clinical record for Resident I was reviewed on 3/21/11 at 10:10 p.m. The record indicated the resident was readmitted from the hospital on 3/8/11. The Resident - Data Collection, dated 3/8/11 at 12:30 p.m., indicated in the section for Skin Condition that the resident had a PICC line to the left upper extremity.<br><br>The only physician's orders related specifically to the PICC line upon readmission indicated: "Flush | | | |

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| | PICC line with 5 cc N/S [normal saline] one time a day."<br><br>The resident's plan of care for the problem of IV Therapy, dated 1/7/11, and updated 3/10/11, included Interventions of "Monitor IV [intravenous ] site q [every] day after each IV med [medication] administration for redness, warmth, pain & edema."<br><br>Weekly Skin Condition reports for 3/14/11 and 3/21/11 did not indicate the presence of the resident's PICC line.<br><br>Nurse's Notes indicated an assessment of the PICC line was completed on 3/9/11. Nurse's Notes from 3/9/11 through 3/21/11 failed to indicate assessments of the PICC line.<br><br>On 3/23/11 at 11:15 a.m., with the facility's Nurse Consultant, Resident I's PICC line to the left upper arm was observed. The | | | |

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| | Nurse Consultant looked at the transparent occlusive dressing and indicated the date on it was 3/22/11, 2:00 to 10:00 p.m. During interview at this time, Resident I indicated the dressing was changed because it was "leaking." The resident indicated removal of the PICC line was not planned.<br><br>The facility's policy related to "Dressing Changes for Midline and Central Catheters" was provided by the Nurse Consultant on 3/23/11 at 11:00 a.m. Review of the policy indicated, "...4. Access Site Inspection a. The catheter-skin junction site should be visually inspected or palpated for tenderness daily through the intact dressing. b. In the event of tenderness at the site, fever without obvious source, or symptoms of local or blood stream infection, the dressing should be removed and the site inspected directly. 5. Documentation in the patient's permanent medical record should | | | |

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| | reflect routine assessment and condition of the catheter-skin junction site."<br><br>3. On 3/22/11 at 10:20 a.m., LPN #3 was overheard on the phone at the Nurse's Station speaking with someone about (name of Resident M) in regard to discontinuing the resident's PICC line after the next two doses of medication.<br><br>On 3/22/11 at 6:00 p.m., Resident M was observed entering the building on a gurney accompanied by Emergency Medical Technicians. During interview on 3/22/11 at 6:15 p.m., LPN #10 indicated Resident M had been sent to the hospital for replacement of his PICC line which was not functioning properly, but the hospital did not have staff to replace the line, and he would need to return to the hospital the next day.<br><br>The clinical record for Resident M | | | |

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| | was reviewed on 3/23/11 at 12:45 p.m. The record indicated the resident was readmitted from the hospital on 3/15/11. The Resident - Data Collection, dated 3/15/11 at 6:00 p.m., indicated in the section for Skin Condition that the resident had a PICC line in the upper left arm.<br><br>The only physician's orders upon readmission on 3/15/11 related to the PICC line were for administration of IV antibiotics and flushes to the line.<br><br>The Weekly Skin Check Sheet for 3/19/11 failed to indicate presence of the PICC line. Documentation failed to indicate a Weekly Wound Evaluation Flow Record related to the PICC insertion site.<br><br>Nurse's Notes for 3/15/11 through 3/22/11 failed to indicate assessment of the PICC insertion site. | | | |

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| | The Medication Administration Record (MAR) indicated a physician's order was received on 3/22/11 for "PICC line drsg to be changed q 7 days & prn [as needed]." A nurse's initials on 3/23/11 indicated the dressing was changed that day, which was the first dressing change since readmission on 3/15/11.<br><br>4. During observation of medication pass on 3/22/11 at 12:40 p.m., LPN #7 prepared medications for Resident P, dispensing four medications into a medication cup. During interview at this time, LPN #7 indicated the resident also gets a pain medication daily, and she opened the narcotics drawer on the medication cart and dispensed a medication labeled, "Lortab 5/500, one tablet by mouth, three times daily as needed" into the medication cup. The nurse entered the resident's room, chatted with the resident, and administered the medications with water. The nurse | | | |

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| | did not assess for pain to determine the need for the medication.<br><br>This federal tag relates to Complaint IN00087744.<br><br>3.1-31(a) | | | |

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| F0282 SS=E | Based on observation, interview, and record review, the facility failed to ensure physician's orders were followed related to blood sugar monitoring before meals. The deficient practice affected 4 of 7 residents observed receiving blood sugar checks scheduled before meals in a sample of 25. (Residents O, R, S and P) The facility also failed to ensure residents' medications were administered as ordered for 2 of 17 residents observed during medication administration in a sample of 25. (Residents T and P)<br><br>Findings include:<br><br>During interview on 3/22/11 at 4:45 p.m., LPN #6 pointed to a list of resident names on top of the medication cart and indicated she needed to complete blood sugar checks on all the residents except one who was out of the facility visiting his brother. The list included, but was not limited to, the | F0282 | **F282 483.2(k)(3)(ii) SERVICES BY QUALIFIES PERSONS/PER CARE PLAN** I. Finger stick blood glucose tests are being completed prior to meals for Residents O, R. S and P. Resident P is receiving insulin as prescribed. The haldol order was clarified for Resident T and she is receiving medication as prescribed.II. All residents receiving finger stick blood glucose testing and medications were identified. Finger stick blood glucose test orders and medication orders were reviewed by RN to assure appropriateness of orders. III. The facility's medication administration policy was reviewed and found to be appropriate by QA. LPN #3, LPN#6 and all licensed nurses will be educated on medication administration including but not limited to Right Time and Right Dose. IV. The DON or designee will complete medication administration competencies with all licensed nurses. The DON or designee will conduct random (6 unannounced on varied shifts) audits of medication administration monthly for 3 months. The DON or designee will report to QA monthly.V. Compliance Date: April 22, 2011 | 04/22/2011 |

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| | names of Residents O, R, S, and P.<br><br>The facility's Cart Delivery Time schedule was provided by the Director of Nursing on 3/22/11 at 10:45 a.m. Review of the schedule for the delivery of the meal carts for the hall of Residents O, R, S, and T indicated three carts would be delivered between 5:05 p.m. and 5:30 p.m.<br><br>1. On 3/22/11 at 5:07 p.m., LPN #6 entered the room of Resident O and performed a blood sugar check. The resident was seated at his over the bed table already eating his supper of pizza, corn, salad, cottage cheese and beverage. After the blood sugar check, LPN #6 indicated the blood sugar was 411, and she administered 25 units insulin as ordered on a sliding scale based on the blood sugar test.<br><br>The clinical record for Resident O was reviewed on 3/22/11 at 5:45 p.m. The record indicated | | | |

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| | physician's orders for March 2011 including, but not limited to, "Glucose monitor per finger stick before meals and at bedtime."<br><br>2. On 3/22/11 at 5:20 p.m., LPN #6 was observed to enter the room of Resident S and perform a blood sugar check. The resident was seated at her over the bed table. LPN #6 indicated to the resident that she was running behind on checking blood sugars. The resident's empty dinner tray was on her over the bed table . During interview after the blood sugar check, the nurse indicated that based on the resident's orders, no sliding scale insulin was necessary.<br><br>3. On 3/22/11 at 5:23 p.m., LPN #6 was observed to enter the room of Resident R. Resident R was in bed with her over the bed table in front of her. On the table was her meal tray, and the resident was observed eating mashed potatoes. LPN #6 performed a blood sugar check for | | | |

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| | Resident R and indicated the blood sugar was 326 and administered 5 units of insulin on a sliding scale as ordered based on the test results.<br><br>The clinical record for Resident R was reviewed on 3/22/11 at 5:45 p.m. The record indicated physician's orders including, but not limited to, "Glucose monitor p/ [per] finger stick ac [before meals] and hs [bedtime]."<br><br>4A. On 3/22/11 at 5:30 p.m., LPN #6 was observed to enter the room of Resident P and perform a blood sugar check. The resident was seated on her bed with the over the bed table in front of her. She indicated her supper was good. LPN #6 indicated to the resident, "Now that you're almost through, we'll get your Accucheck [blood sugar test]." The resident indicated she was finished with her meal. LPN #6 completed the blood sugar test. | | | |

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| | LPN #6 indicated that based on the blood sugar check, she would administer the resident's routine insulin, but no sliding scale insulin would be needed, based on the blood sugar test. LPN #6 administered 15 units of Novolog 100 units/ml, which she obtained from the Emergency Drug Kit in the medication room.<br><br>The clinical record for Resident P was reviewed on 3/22/11 at 5:45 p.m. The record indicated physician's orders for March 2011 including, but not limited to, "Accu[check mark] [blood sugar check] before meals and bedtime. May also do prn [as needed]" and "Novolog 15 units before meals." The insulin administration was scheduled at 7:00 a.m., 12:00 p.m., and 4:00 p.m.<br><br>5. During medication pass on 3/21/11 between 10:55 p.m. and 11:25 p.m., LPN #3 was observed pouring a liquid medication from a | | | |

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| | bottle of Haldol [restlessness] liquid with a label indicating, "Take 0.5 ml (1 mg) subling [sublingual] every 4 hours routinely. May increase to 2 mg [1 ml] if 1 mg ineffective." The medication bottle did not indicate a label noting a change in physician's order. LPN #3 administered 0.5 ml (1 mg) of the liquid medication to Resident T.<br><br>The clinical record for Resident T was reviewed on 3/21/11 at 11:25 p.m. after the medication pass.<br><br>The record indicated a physician's telephone order dated 3/21/11 at 4:15 p.m., for "Give Haldol 1 mg now then start Haldol 2 mg per previous order." The previous order, dated 3/20/11, indicated, "[Arrow pointing up] Haldol to 1 mg p.o. [by mouth] q [every] 4 [symbol for hours] routine. May [arrow pointing up] to 2 mg if 1 mg ineffective."<br><br>The Interdisciplinary Hospice | | | |

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| | Communication, dated 3/21/11 from 3:15 p.m. to 5:30 p.m. indicated, "...Reviewed meds [medications] & discussed with SNF [skilled nursing facility] - [arrow pointing up] Haldol to 2 mg every 2 [sic] hrs [hours] per order...."<br><br>During interview about the order for the liquid Haldol on 3/23/11 at 11:00 a.m., the facility's Nurse Consultant indicated she understood the order on 3/21/11 at 4:15 p.m. to mean that the previous order for 1 to 2 mg of liquid Haldol every four hours should be followed, instead of administering 2 mg with each dose. The Consultant indicated the physician should have been contacted to clarify the medication order and that the order had now been clarified. She provided copy of a physician's order dated 3/22/11 that included, but was not limited to, "Increase Haldol to 2 mg po/sl [by mouth/sublingual]." The time | | | |

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| | frame for the administration was not indicated on the order.<br><br>3.1-35(g)(2) | | | |

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| F0328 SS=D | Based on observation, record review, and interview, the facility failed to ensure care was planned and implemented related to residents with PICC (peripherally inserted central catheters) requiring routine assessment and dressing changes. The deficient practice affected 2 of 2 residents reviewed related to PICC lines in a sample of 25 residents. (Residents I and M)<br><br>Findings include:<br><br>1. During observation and interview on 3/21/11 at 9:45 p.m., Resident I indicated she had been in the hospital recently and pointed to an intravenous tubing observed in her upper left arm.<br><br>During interview on 3/21/11 at 10:05 p.m., LPN #8, who indicated she was providing care on Resident I's hall this evening, indicated none of the residents on her hall had a PICC line. | F0328 | **F328 483.25(k) TREATMENT/CARE F0R SPECIALNEEDS** I. Orders for dressing changes and daily assessment of PICC site were obtained for Resident I. These dressings are being completed as ordered. Resident I's PICC site is intact with no signs of infection or compromise. Orders for dressing changes and daily assessment of PICC site were obtained for Resident M. These dressings are being completed as ordered. Resident M's PICC site is intact with no signs of infection or compromise.II. All residents were reviewed for the presence of PICC lines. No other residents were identified.III. The facility's policies for PICC line care was reviewed and deemed appropriate by QA. All licensed nurses will be educated on PICC line care. IV. The IDT will review new orders daily to identify new PICC lines and to assure proper care orders are received. The IDT will review the documentation of those residents currently with PICC lines weekly to assure proper dressing change and assessments are being completed. The IDT will report QA monthly. V. Compliance Date: April 22, 2011 | 04/22/2011 |

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| | The clinical record for Resident I was reviewed on 3/21/11 at 10:10 p.m. The record indicated the resident was readmitted from the hospital on 3/8/11. The Resident - Data Collection, dated 3/8/11 at 12:30 p.m., indicated in the section for Skin Condition that the resident had a PICC line to the left upper extremity.<br><br>The only physician's orders related specifically to the PICC line upon readmission indicated: "Flush PICC line with 5 cc N/S [normal saline] one time a day."<br><br>The resident's plan of care for the problem of IV Therapy, dated 1/7/11, and updated 3/10/11, included Interventions of "Monitor IV [intravenous ] site q [every] day after each IV med [medication] administration for redness, warmth, pain & edema." Documentation on the care plan failed to indicate the intervention of dressing changes to the IV site. | | | |

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Weekly Skin Condition reports for 3/14/11 and 3/21/11 did not indicate the presence of the resident's PICC line.

Nurse's Notes indicated an assessment of the PICC line was completed on 3/9/11. Nurse's Notes from 3/9/11 through 3/21/11 failed to indicate assessments of the PICC line or changes to the PICC line dressing.

During interview on 3/22/11 at 12:40 p.m., the day shift nurse, LPN #7, indicated she had never changed the PICC dressing for Resident I, and she indicated the "other nurse" was checking on it.

During interview on 3/22/11 at 2:00 p.m., LPN #4, who was the evening shift nurse indicated she had never changed the PICC dressing for Resident I. LPN #4 then checked the Treatment Record and indicated she was unable to locate

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| | documentation of the Resident I's PICC dressing being changed.<br><br>On 3/23/11 at 11:15 a.m., with the facility's Nurse Consultant, Resident I's PICC line to the left upper arm was observed. The Nurse Consultant looked at the transparent occlusive dressing and indicated the date on it was 3/22/11, 2:00 to 10:00 p.m. At this time Resident I indicated the dressing was changed because it was "leaking." The resident indicated removal of the PICC line was not planned.<br><br>During interview on 3/23/11 at 2:20 p.m., the ADON (Assistant Director of Nursing) provided copy of a physician's order dated 3/22/11 indicating, "[Symbol for change] PICC drsg [dressing] R[sic]UA [right upper arm] on 3/22/11 & q [every] 7 days."<br><br>The facility's policy related to "Dressing Changes for Midline and | | | |

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| | Central Catheters" was provided by the Nurse Consultant on 3/23/11 at 11:00 a.m. Review of the policy indicated, "3. Routine Dressing Change...b. The transparent dressing should be changed at least every 7 days....4. Access Site Inspection a. The catheter-skin junction site should be visually inspected or palpated for tenderness daily through the intact dressing. b. In the event of tenderness at the site, fever without obvious source, or symptoms of local or blood stream infection, the dressing should be removed and the site inspected directly. 5. Documentation in the patient's permanent medical record should reflect routine assessment and condition of the catheter-skin junction site."<br><br>2. On 3/22/11 at 10:20 a.m., LPN #3 was overheard on the phone at the Nurse's Station speaking with someone about (name of Resident M) in regard to discontinuing the | | | |

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| | resident's PICC line after the next two doses of medication.<br><br>On 3/22/11 at 6:00 p.m., Resident M was observed entering the building on a gurney accompanied by Emergency Medical Technicians. During interview on 3/22/11 at 6:15 p.m., LPN #10 indicated Resident M had been sent to the hospital for replacement of his PICC line which was not functioning properly, but the hospital did not have staff to place the line, and he would need to return to the hospital the next day.<br><br>The clinical record for Resident M was reviewed on 3/23/11 at 12:45 p.m. The record indicated the resident was readmitted from the hospital on 3/15/11. The Resident - Data Collection, dated 3/15/11 at 6:00 p.m., indicated in the section for Skin Condition that the resident had a PICC line in the upper left arm. | | | |

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| | The only physician's orders upon readmission on 3/15/11 related to the PICC line were for administration of IV antibiotics and flushes to the line. Documentation failed to indicate a physician's order related to the PICC dressing at the time of readmission.<br><br>The Weekly Skin Check Sheet for 3/19/11 failed to indicate presence of the PICC line. Documentation failed to indicate a Weekly Wound Evaluation Flow Record related to the PICC insertion site.<br><br>Nurse's Notes for 3/15/11 through 3/22/11 failed to indicate assessment of the PICC insertion site or of a dressing change to the site.<br><br>The Medication Administration Record (MAR) indicated a physician's order was received on 3/22/11 for "PICC line drsg to be changed q 7 days & prn [as needed]." A nurse's initials on | | | |

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| | 3/23/11 indicated the dressing was changed that day, which was the first dressing change since readmission on 3/15/11.<br><br>3.1-47(a)(2) | | | |

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| F0425 SS=E | Based on observation, interview, and record review, the facility failed to ensure policies and procedures were followed for labeling over-the-counter medications, marking medications with a date opened, and indicating a change in physicians orders on medication containers. The deficient practice affected 5 of 17 residents whose medication administration was observed in a sample of 25 residents. (Residents V, W, X, Y, Z)<br><br>Findings include:<br><br>Facility policies related to medication management were provided by the facility's Nurse Consultant on 3/23/11 at 11:00 a.m. Review of the policy for "Medication Labels" indicated, "...E. Nonprescription mediations not labeled by the pharmacy are kept in the manufacturer's original container and identified with the resident's name. Facility personnel | F0425 | **F425 483.60(a),(b) PHARMACEUTICAL SERVICES-ACCURATE PROCEDURES** I. The medications for residents V,W,X,Y,Z were reviewed by RN and are labeled appropriately.II. All medications were reviewed by RN to assure proper labeling. All OTC medications were labeled according to the facility's policy. All multidose medications were dated with date opened. All medications whose orders had been changed were labeled with "change in order" stickers.III. The facility's policy for Medication Storage and Labeling was reviewed and found to be appropriate by QA. LPNs #3,6 and 9 and all licensed nurses and QMA's will be educated on medication storage and labeling.IV. The consulting pharmacist will inspect medication carts during monthly visits and report any discrepancies to the DON or designee for correction. The DON or designee will make corrections and report to QA monthly.V. Compliance Date: April 22, 2011 | 04/22/2011 |

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| | may write the resident's name on the container or label as long as the required information is not covered....F. 1) If the physician's directions for use change or the label is inaccurate, the nurse may place a 'change of order - check chart' or an equivalent label on the container indicating there is a change in directions for use, taking care not to cover important label information...." The policy for "Vials and Ampules of Injectable Medications" indicated, "...B. The date opened and the initials of the first person to use the vial are recorded on multidose vials on the vial label or an accessory label affixed for that purpose....F. Medication in multidose vials may be used until the manufacturer's expiration date and/or for the length of time allowed by the manufacturer after opened."<br><br>1. During observation of medication pass on 3/22/11 at 1:35 p.m., LPN #9 prepared a | | | |

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| | medication for Resident V. The medication bottle did not include a pharmacy label or a resident's name. The bottle appeared to be an over the counter medication named Niacinamide 500 mg. Review of the Medication Administration Record (MAR) at this time indicated, "Niacinamide 500 mg, 1 by mouth 3 times daily." During interview at this time, LPN #9 indicated she just knew whose medication this was, because Resident V was the only resident who received this medication. LPN #9 prepared and administered the medication to Resident V.<br><br>The clinical record for Resident V was reviewed immediately after the medication pass. The record indicated physician's orders for March 2011 as indicated on the Medication Administration Record: "Niacinamide 500 mg, 1 by mouth 3 times daily."<br><br>2. During observation of | | | |

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| | medication pass on 3/22/11 at 1:45 p.m., LPN #9 prepared a medication for Resident W. The medication bottle did not include a pharmacy label or a resident's name. The bottle appeared to be an over the counter medication named Ocean Premium Nasal Spray. No date of opening was indicated on the bottle, and during interview at this time, LPN #9 indicated there was no way to know when the bottle was opened. LPN #9 indicated Resident W was the only resident with this medication, so she knew it belonged to the resident. LPN #9 administered one spray to each nostril of Resident W.<br><br>The clinical record for Resident W was reviewed immediately after the medication pass. The record indicated physician's orders including, but not limited to, "Saline mist nasal spray, 1 spray each nostril, 3 times daily."<br><br>3. During observation of the | | | |

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| | medication pass on 3/21/11 between 10:55 and 11:25 p.m., LPN #3 prepared a medication labeled as follows for Resident X: "Lortab 7.5/500, take 1 -2 tabs by mouth every 6 hours as needed for pain." No change of order label was observed on the medication box. LPN #3 dispensed two Lortab 7.5/500 tablets into a medication cup and indicated during interview at this time that the order for the medication had been changed but was not reflected on the label. LPN #3 pointed to the MAR and indicated the new order for two Lortab 7.5/500 every midnight.<br><br>The clinical record for Resident X was reviewed immediately after the medication pass. The record indicated physician's orders, dated 3/8/11, for: "N.O. [new order] Lortab 7.5/500 mg tabs. Take 2 tabs p.o. [by mouth] every night at 12 AM (midnight) and PRN [as needed] 1 tab q [every] 6 hours for moderate pain. 2 tabs q 6 hours for | | | |

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| | severe pain."<br><br>4. During observation of medication pass on 3/22/11 at 4:20 p.m., LPN #6 looked at the Medication Administration Record for Resident Y and indicated, "Looks like new orders." LPN #6 prepared Humalog Insulin from a bottle in a box labeled, "Humalog Insulin...16 units SQ [subcutaneous] before supper." No change of order label was observed 8 extra units on the medication box. LPN #6 prepared 24 units of Humalog insulin plus 8 extra units of Humalog insulin, based on the resident's blood sugar test.<br><br>The clinical record for Resident Y was reviewed after the medication pass. The record indicated a physician's order, dated 3/21/11 for "Humalog 24 units at supper."<br><br>5. During observation of the medication pass on 3/22/11 at 5:00 p.m., LPN #6 checked the blood | | | |

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| | sugar for Resident Z. During interview at this time, LPN #6 indicated she would give Resident Z three units of Humalog Insulin and removed the resident's bottle of insulin from its box. LPN #6 indicated the open date was not indicated on the bottle or box. She also indicated it looked like a "pretty new bottle" and administered insulin from the bottle.<br><br>During interview on 3/23/11 at 11:45 a.m., the facility's Nurse Consultant indicated she had checked on the over the counter medications for Residents V and W. The Consultant indicated the boxes for the medications had been discarded by the nurses, who needed to be educated related to the labeling.<br><br>This federal tag relates to Complaint IN00087744.<br><br>3.1-25(j) | | | |

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| | 3.1-25(k)(5)<br>3.1-25(l)(1)<br>3.1-25(l)(2)<br>3.1-25(l)(3) | | | |
| F0441<br>SS=E | Based on observation, interview, and record review, the facility failed to ensure the nurse checking residents' blood sugar sanitized the test meter between residents as required by facility policy. The deficient practice had the potential to affect 6 of 7 residents observed receiving blood sugar checks in a sample of 25. (Residents AA, Z, O, R, S and P) Resident Y was the first resident observed to receive a blood sugar check with the machine.<br><br>Findings include:<br><br>1. During observation of medication pass on 3/22/11 at 4:20 p.m., LPN #6 checked the blood sugar of Resident Y, using a lancet to prick the resident's finger to obtain the blood and a hand-held | F0441 | **F441483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS** I. All blood glucose machines were disinfected. Residents AA, Z, O, R, S, and P were assessed and show no signs of infection related to finger stick blood glucose testing.II. All residents were reviewed for the use of finger stick blood glucose testing. Those residents requiring this testing were identified and assessed for signs of infection related to blood glucose testing. No evidence of infection was found.III. The facility's policy for Cleaning of Glucometer was reviewed and found to be appropriate by QA. LPN's #4,6 and all licensed nurses will be educated on Cleaning of Glucometer.IV. The DON or designee will complete random audits (6 unannounced on varied shifts) of blood glucose testing and subsequent cleaning of machine weekly for four weeks, and then monthly for two months. The DON or designee will report to QA monthly.V. Compliance Date: April 22, 2011 | 04/22/2011 |

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| | Microdot blood glucose meter. After completing the test, the nurse placed the meter on top of the medication cart. LPN #6 did not sanitize the meter.<br><br>2. After administering another resident's medication, LPN #6 prepared to check the blood sugar of Resident AA on 3/22/11 at 4:35 p.m., using the Microdot blood glucose meter on top of the medication cart. LPN #6 inserted the test strip into the machine and obtained lancets and gloves and prepared to enter Resident AA's room.<br><br>During interview at this time related to sanitizing the Microdot machine, LPN #6 indicated she was probably supposed to clean the machine with alcohol swabs. At 4:40 p.m., LPN #4 approached the medication cart, and LPN #6 asked LPN #4 about the cleaning policy for the Microdot meter. LPN #4 indicated she used alcohol wipes and indicated you could also use | | | |

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| | antimicrobial wipes, which they sometimes have. LPN #4 indicated she would check about the policy. At 4:55 p.m., LPN #4 returned to the medication cart with a policy and indicated the wipes in the Medication Room could be used to sanitize the Microdot. She obtained a tub of pop-up wipes labeled "Good and Clean Disinfectant Wipes." LPN #6 wiped the Microdot meter with a wipe and proceeded to check blood sugars on the following residents, using a wipe after each check: Resident AA at 4:57 p.m., Resident Z at 5:02 p.m., Resident O at 5:07 p.m., Resident S at 5:20 p.m., Resident R at 5:25 p.m., and Resident P at 5:30 p.m.<br><br>The policy provided by LPN #4 on 3/22/11 at 4:55 p.m. was titled "Infection Control - Blood Glucose Machine Safe Injection Practices to Prevent Resident to Resident Transmission of Bloodborne Pathogens." The policy included, | | | |

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| | but was not limited to, "3. Be sure to clean and disinfect the blood glucose machine environmental surface with Sani-wipes (or approved antimicrobial/germicidal wipe) before and after testing the resident's blood glucose and between each resident use."<br><br>3.1-18(b)(2) | | | |

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| F0502 SS=E | Based on observation, interview, and record review, the facility failed to implement test controls as required by manufacturer's instructions to ensure accuracy of function of blood glucose meter used for monitoring residents' blood sugar. The deficient practice had the potential to affect 7 of 7 residents observed during blood glucose monitoring in a sample of 25. (Residents Y, AA, Z, O, S, R, and P)<br><br>Findings include:<br><br>During observation of medication pass on 3/22/11 at 4:20 p.m., LPN #6 prepared to check the blood sugar of Resident Y using the Microdot blood sugar meter. LPN #6 opened a new bottle of test strips and wrote the date on the bottle. A control solution test was not run on the testing device.<br><br>During observation on 3/22/11 between 4:57 p.m. and 5:35 p.m., LPN #6 used the same bottle of test | F0502 | **F502 483.75(j)(1) PROVIDE/OBTAIN LABORATORY SERVICE-QUALITY/TIMELY** I. All glucometers were control tested initially and have been subsequently control tested with the opening of each new bottle of test strips.II. All glucometers were control tested initially and have been subsequently control tested with the opening of each new bottle of test strips.III. LPN#6 and all licensed nurses will be educated on the proper control testing of the Microdot meter according to manufacturer's guidelines. Directions for control testing will be made readily available for all nurses.IV. The DON or designee will conduct random (6 unannounced on varied shifts) audits of glucometer control testing comprehension weekly for four weeks then monthly for two months. The DON or designee will report to QA monthly.V. Compliance Date: April 22, 2011 | 04/22/2011 |

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| | 155616 | A. BUILDING _____ B. WING _____ | 03/23/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LANDMARK NURSING AND REHABILITATION | 201 E ELM ST NEW ALBANY, IN47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | strips to measure blood sugar for Residents AA, Z, O, S, R, and P.<br><br>During interview on 3/22/11 at 5:00 p.m., LPN #6 indicated the calibration checks on the Microdot meter are done on night shift.<br><br>The User Manual for the Microdot Blood Glucose Monitoring System was provided by the facility's Nurse Consultant on 3/23/11 at 11:35 a.m. The manual indicated on page 7: "Using Control Solutions properly is important for accurate testing. Low, Normal, and High controls are available. You should test with control solutions: ...When you begin using a new vial of strips...."<br><br>3.1-49(a) | | | |